Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TEXAS 76013-9633	MFDR Tracking #:	M4-08-7242-01 (previously M4-08-1141-01)
Respondent Name and Box #: Liberty Insurance Corporation Box #: 28		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "HRA has been hired by Northwest Texas Center to audit their Workers Compensation claims. We have found in this audit…that the payment received is not considered a 'fair and reasonable' amount for the ER line item charge. As a common practice, we review the ER charges **for at least 75%** line item reimbursement. We have come to this conclusion, as this is a standard practice with most carriers. In addition, the following line items should be reimbursed at the Medicare Fee Schedule X 125%, which is listed in the fee schedule…HCPS 71010…72070…73070…73090…72160…72125…76376…"

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $554.37
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The billed charges for 03/09/07 were reimbursed at a fair and reasonable rate as determined per procedure designated on the bill."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
03/09/2007	W10(Z585),W1(Z652),W1(Z710),50(Z306), 18(U301),42(Z585),42(Z710),150(Z652), W1(Z345)	Emergency Room Visit	$554.37	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - W10(Z585) — "The charge for this procedure exceeds fair and reasonable."
   - W1(Z652) — "Recommendation of payment has been based on a procedure code which best describes services rendered."

- W1(Z710) — "The charge for this procedure exceeds the Fee Schedule allowance."
- W1(3450) — "Left Side."
- 50(Z306) — "Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure."
- 18(U301) — "This item was previously submitted and reviewed with notification of decision issues to payer/provider (duplicate invoice)."
- 42(Z585) — "The charge for this procedure exceeds fair and reasonable."
- 42(Z710) — " The charge for this procedure exceeds the Fee Schedule allowance."
- 150(Z652) — "Recommendation of payment has been based on a procedure code which best describes services rendered."

2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. This dispute relates to outpatient emergency services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401(a)(5), effective August 1, 1997, 22 TexReg 6264, which provide that such services shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.
4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on October 9, 2007. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
7. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue"… This request for medical fee dispute resolution was received by the Division on October 9, 2007. Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).
8. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Division rule at 28 TAC §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"… The requestor's position statement asserts that "**Per the Medicare Fee Schedule allowable at 125% and the ER line at 75% of billed charges the outstanding balance still due for this claim is $554.37.**" However, the requestor does not explain or submit documentation to support how payment of 75% of billed charges would result in a fair and reasonable reimbursement for ER line or how payment of the Medicare Fee Schedule Allowable at 125% would result in a fair and reasonable reimbursement for the services billed under CPT codes 71010, 72070, 73070, 73090, 72160, 72125 and 76376. The requestor asserts that "As a common practice, we review the charges for **at least a 75%** line item reimbursement. We have come to this conclusion, as this is a standard practice with most carriers." Review of the submitted documentation finds that the requestor has not provided evidence to support that 75% line item reimbursement is a standard practice with most carriers. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decision,

or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodologies. The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charges for similar treatment of an injured individual or an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. Additionally, the requestor did not provide documentation, such a Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. The requestor has not submitted documentation sufficient to satisfy the requirements of Division rule at 28 TAC §133.307(c)(2)(G).

9. Moreover, the Division has determined that a reimbursement methodology based upon a percentage of billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

   "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, would require additional Commission resources."

   Thorough review of the documentation submitted by the requestor finds that the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Divisions rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401, §133.250
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		December 3, 2009
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.